CHAPTER 58

CERTIFIED NURSE MIDWIFE SERVICES

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SUBCHAPTER 1. GENERAL PROVISIONS

10:58-1.1 Purpose

The purpose of this chapter is to provide the standards for approval of certified nurse midwives as independent providers of services, within their licensed scope of practice and in accordance with the requirements of N.J.A.C. 13:35-2A, to New Jersey Medicaid/NJ FamilyCare-Plan A fee-for- service beneficiaries.

10:58-1.2 Scope

(a) The rules in this chapter govern reimbursement made directly to a nurse midwife provider. Reimbursement shall not be made to a certified nurse midwife unless the nurse midwife has been approved as a Medicaid/NJ FamilyCare provider, in accordance with the provisions of this chapter and applicable provisions of N.J.A.C. 10:49.

(b) Reimbursement may be made for services provided by a certified nurse midwife employed by a physician or physician/practitioner group (N.J.A.C. 10:54), by an independent clinic (N.J.A.C. 10:66), or by a hospital (N.J.A.C. 10:52), in accordance with the applicable rules.

(c) The rules in this chapter govern the provision of fee-for-service nurse midwifery services provided to Medicaid and NJ FamilyCare-Plan A fee-for- service beneficiaries. Nurse midwifery services provided to beneficiaries who are enrolled in HMOs shall be governed by the individual HMO contract.

10:58-1.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context indicates otherwise.

"Birth center" means a health care facility or distinct part of a health care facility, licensed as such by the New Jersey State Department of Health and Senior Services, which provides routine prenatal and intrapartal care to low- risk, uncomplicated maternity patients who are expected to deliver neonates of a weight greater than 2,499 grams, and of at least 36 weeks gestational age, and who require a stay of less than 24 hours after birth.

"Clinical laboratory services" means professional and technical laboratory services performed by a clinical laboratory certified by HCFA in accordance with the Clinical Laboratory Improvement Act (CLIA) 42 U.S.C. 1396a(9) and ordered by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice as defined by the laws of the State of New Jersey and/or of the state in which the practitioner practices.

"CNM" means certified nurse midwife.

"Early and Periodic Screening, Diagnosis and Treatment (EPSDT)" means a preventive and comprehensive health program for Medicaid/NJ FamilyCare-Plan A fee-for-service beneficiaries under 21 years of age, including the assessment of an individual's health needs through initial and periodic examinations (screenings), the provision of health education and guidance, and the assurance that any identified health problems are diagnosed and treated at the earliest possible time.

"HealthStart Comprehensive Maternity Care Services Provider" means a certified nurse midwife who provides either directly or indirectly through linkage with other health care providers, in independent clinics and hospital outpatient departments; or physicians' offices, a comprehensive package of maternity care services which includes two components. "Medical Maternity Care" and "Health Support Services." (See N.J.A.C. 10:58-1.5 and 2.16 for requirements.)

"NJ FamilyCare-Plan A fee-for-service" means that coverage provided a beneficiary during the period of time between application and the time the beneficiary is enrolled in managed care.

"Nurse midwifery services" means services provided by a certified nurse midwife to manage the care of essentially normal women during the maternity cycle; to provide care to essentially normal newborns at the time of delivery; and to provide well-woman health care. Nurse midwifery services are provided within the scope of practice of nurse midwifery and the rules of the Board of Medical Examiners of the State of New Jersey. (See N.J.A.C. 13:35- 2A.)

"Prescribed drugs" means simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance, that are:

1. Prescribed by a practitioner licensed or authorized by the State of New Jersey, or the state in which he or she practices, to prescribe drugs and medicine within the scope of his or her license and practice;

2. Dispensed by licensed pharmacists in accordance with regulations promulgated by the New Jersey Board of Pharmacy, N.J.A.C. 13:39; and

3. Dispensed by licensed pharmacists on the basis of a written prescription that is maintained in the pharmacist's records.

"Routine intrapartal care" means labor and delivery services not requiring surgical intervention.

"Routine prenatal care" means medical supervision provided to pregnant women during pregnancy.

"Well-woman health care" means those preventive and referral services which may include family planning, reproductive health care counseling, and reproductive systems health care screening.

10:58-1.4 Application for provider status; certified nurse midwife

(a) Any nurse midwife may apply to the New Jersey Medicaid/NJ FamilyCare programs for approval as a Medicaid/NJ FamilyCare provider, if he or she:

1. Is a registered professional nurse licensed by the New Jersey State Board of Nursing;

2. Is certified by the American College of Nurse Midwives (ACNM) or the American College of Nurse Midwives Certification Council;

3. Shows evidence of continuing competency, as required by the ACNM; and

4. Is registered as a certified nurse midwife by the New Jersey State Board of Medical Examiners.

(b) See N.J.A.C. 10:49-3 for additional requirements for provider participation.

(c) An applicant shall complete a Medicaid Provider Application (FD-20; see N.J.A.C. 10:49, Appendix, Form #8) and a Medicaid Provider Agreement (FD- 62; see N.J.A.C. 10:49, Appendix, Form #9). The forms may be obtained from, and shall be submitted to:

Unisys Corporation

Provider Enrollment

PO Box 4804

Trenton, NJ 08650-4804

(d) The application and agreement shall be accompanied by a photocopy of the applicant's current:

1. License as a registered professional nurse;

2. Registration as a nurse midwife; and

3. Certification from the American College of Nurse Midwives (ACNM) or the American College of Nurse Midwives Council(ACC).

(e) The applicant will receive notification of approval or disapproval from the Medicaid/NJ FamilyCare fiscal agent (Unisys). If approved, the CNM shall be furnished with a provider manual and assigned a Medicaid/NJ FamilyCare provider identification number. The CNM shall use the assigned provider identification number in all communication with the Medicaid/NJ FamilyCare programs and/or the fiscal agent.

10:58-1.5 Application for provider status; HealthStart

(a) A certified nurse midwife who is a Medicaid/NJ FamilyCare provider may also become a HealthStart Comprehensive Maternity Care or HealthStart Maternity Medical Care services provider.

(b) In order to participate as a provider of HealthStart services, the CNM practicing independently or as part of a group shall be a Medicaid/NJ FamilyCare provider and shall meet the HealthStart requirements specified at N.J.A.C. 10:66-3 and in this chapter. A HealthStart provider shall have a valid HealthStart Provider Certificate.

1. An application for a HealthStart Provider Certificate is available from:

New Jersey Department of Health and Senior Services

Division of Family Health Services

50 East State Street

PO Box 364

Trenton, N.J. 08625-0364

10:58-1.6 Application for provider status; birth centers

(a) A birth center shall enroll as a CNM provider in order to receive reimbursement for the use of the facility for labor and delivery services provided at the center.

(b) The birth center shall be licensed by the Department of Health and Senior Services in accordance with the provisions of N.J.A.C. 8:43A-28.

(c) In order to receive reimbursement for professional services provided by a CNM employed by the birth center, the birth center shall enroll as a CNM provider and the CNM employed by the birth center shall meet the provider requirements in N.J.A.C. 10:58-1.4(a).

(d) When a CNM not employed by a birth center provides professional services at the birth center as an independent provider, the CNM shall bill Medicaid/NJ FamilyCare directly for those professional services.

(e) The birth center shall complete the Medicaid/NJ FamilyCare Provider Application (FD-20), the Provider Agreement (FD-62) and the Ownership and Control Interest and Disclosure Statement (HCFA-1513).

1. The birth center shall include with the application a copy of its license, a list of all the CNMs employed by the center, together with their CNM Medicaid/NJ FamilyCare provider numbers, and copies of the CNMs' licenses. The application and all attachments shall be submitted to:

Provider Enrollment

Unisys Corporation

Mail Code #9

PO Box 4804

Trenton, NJ 08650-4804

2. Each CNM employed by the birth center shall have a provider servicing number. The birth center shall report this number when billing Medicaid/NJ FamilyCare for CNM services.

(f) For information regarding reimbursement for pre-natal and post natal care, see N.J.A.C. 10:58-2.16 and 3.6.

(g) Upon signing and returning the Medicaid/NJ FamilyCare Provider Application, the Provider Agreement and other enrollment documents to the New Jersey Medicaid/NJ FamilyCare programs, the birth center will receive written notification of approval or disapproval.

(h) Each approved birth center shall notify the New Jersey Medicaid/NJ FamilyCare programs a minimum of 30 days prior to the relocation or closing of its facilities.

10:58-1.7 Basis of reimbursement

(a) Reimbursement for certified nurse midwifery services shall be based upon the provider's usual and customary charge or the allowance determined by the Commissioner of the Department of Human Services and contained in N.J.A.C. 10:58-3, whichever is less.

(b) A certified nurse midwife who is approved as a provider of services by the New Jersey Medicaid or the NJ FamilyCare programs, and who practices independently and not as part of a physician group or other organized medical care entity, may be directly reimbursed by the New Jersey Medicaid or NJ FamilyCare-Plan A fee-for-service programs, in accordance with the provisions of this chapter.

(c) The basis for reimbursement of services provided in a birth center is as follows:

1. The birth center shall receive a facility fee of $1,300, exclusive of laboratory, drugs, and professional fees, for beneficiaries attended on-site during labor and delivery.

2. A birth center shall receive a facility fee of $500.00, exclusive of laboratory, drugs, and professional fees, for beneficiaries who are admitted to the birth center in labor but subsequently transferred to a hospital.

3. The HCPCS codes for billing for birth center facility services are described in N.J.A.C. 10:58-3.5(g).

4. A birth center shall be reimbursed for professional CNM services provided by a CNM employed by the birth center in accordance with N.J.A.C. 10:58- 1.6(a). The birth center shall not be reimbursed for professional CNM services provided by a CNM who is an independent provider.

5. A physician who provides professional services in a birth center shall bill for his or her services in accordance with N.J.A.C. 10:54-4.33 in order to receive reimbursement for professional services.

6. A birth center billing for laboratory services shall meet all requirements found in N.J.A.C. 10:58-2.9 through 2.13.

7. A birth center billing for medications shall meet all requirements found in N.J.A.C. 10:58-2.17.

8. A birth center may bill for certain injections relative to maternity care or provided to the newborn at the time of delivery, in accordance with N.J.A.C. 10:58-3.5(c).

(d) A certified nurse midwife who is salaried and whose services are reimbursed as part of the hospital's cost shall not bill fee-for-service to the New Jersey Medicaid or NJ FamilyCare-Plan A fee-for-service program. A certified nurse midwife who is practicing in a hospital outpatient department and whose reimbursement is not part of the hospital's cost may bill fee-for- service to the New Jersey Medicaid or NJ FamilyCare-Plan A fee-for-service program, independent of the hospital charges, if the arrangement with the hospital permits it.

(e) When a certified nurse midwife is employed by a physician, nurse midwifery services shall be identified as separate and distinct from physician services by utilization of procedure codes with the "WM" modifier, as designated under the HCFA Common Procedure Coding System (HCPCS) in N.J.A.C. 10:58-3.

(f) When a certified nurse midwife is employed by a clinic, nurse midwifery services shall be identified by utilization of the procedure code with the "WM" modifier as designated under the HCFA Common Procedure Coding System (HCPCS) in N.J.A.C. 10:66.

(g) For the requirements for HealthStart Maternity providers, see N.J.A.C. 10:58-2.5, 3.5 and 3.6(h).

(h) Reimbursement shall not be made for, and clients shall not be asked to pay for, broken appointments.

10:58-1.8 Personal contribution to care requirements for NJ KidCare-Plan C and copayments for NJ KidCare-Plan D

(a) General policies regarding the collection of personal contribution to care for NJ KidCare-Plan C and copayments for NJ KidCare-Plan D services are set forth at N.J.A.C. 10:49-9.

(b) Personal contribution to care for NJ KidCare-Plan C services is $5.00 a visit for office visits, except when the service is provided for prenatal care, preventive care or for family planning services.

1. An office visit is defined as a face-to-face contact with a medical professional which meets the requirements of this chapter and which allows the certified nurse midwife to request reimbursement.

2. Office visits include certified nurse midwife services provided in the office, patient's home, birth center, or any other site, except hospital.

(c) Certified nurse midwives shall not charge a personal contribution to cost of care for services provided to newborns, who are covered under fee-for- service for Plan C; for family planning services, or for prenatal care.

(d) The copayment for nurse midwifery services under NJ KidCare-Plan D shall be $5.00 per office visit;

1. A $10.00 copayment shall apply for services rendered during non-office hours and for home visits.

2. The $5.00 copayment shall apply only to the first prenatal visit.

(e) Certified nurse midwives shall collect the copayment specified in (d) above except as provided in (f) below. Copayments shall not be waived.

(f) Certified nurse midwives shall not charge a copayment for services provided to newborns, who are covered under fee-for-service for Plan D.

10:58-1.9 Recordkeeping; general

(a) The certified nurse midwife shall keep such legible, individual records as are necessary to fully disclose the kind and extent of services provided, and the medical necessity for those services.

(b) Minimum documentation requirements for services performed by the certified nurse midwife shall include a clinical note or a progress note in the clinical record for each visit, which supports the procedure code or codes to be claimed. This information shall be available upon the request of the New Jersey Medicaid/NJ FamilyCare-Plan A fee-for-service programs or their agents.

(c) Documentation of services performed by the CNM shall include, at a minimum:

1. The date of service;

2. The name of the patient;

3. The patient complaint, reason for visit;

4. Subjective findings;

5. Objective findings;

6. An assessment;

7. A plan of care, including, but not limited to, any orders for laboratory work, prescriptions for medications;

8. The signature of the practitioner rendering the service; and

9. Other documentation appropriate to the procedure code being billed. See N.J.A.C. 10:58-3, HCPCS Codes.

(d) Written records in substantiation of the use of a given procedure code shall be available for review and/or inspection if requested by the New Jersey Medicaid/NJ FamilyCare-Plan A fee-for-service programs.

(e) Additional documentation requirements can be found at N.J.A.C. 10:49- 9.4, 9.5 and 9.6.

(f) The CNM's involvement shall be clearly demonstrated in notes reflecting the practitioner's personal involvement with, or participation in, the service rendered.

10:58-1.10 Recordkeeping; initial visit

(a) In order to receive reimbursement for an initial visit, the following documentation, at a minimum, shall be on the record, regardless of the setting where the examination was performed:

1. The chief complaint(s);

2. A complete history of the present illness and related systemic review-- including recordings of pertinent negative findings;

3. A pertinent past medical history;

4. A pertinent family history;

5. A full physical examination pertaining to, but not limited to, the history of the present illness and including recordings of pertinent negative findings; and

6. The working diagnoses and treatment plan including ancillary services and drugs ordered.

10:58-1.11 Recordkeeping; routine or follow-up visits

(a) In order to document the record for reimbursement purposes, the progress note for routine office visits or follow-up care visits shall include the following:

1. In an office:

i. The purpose of the visit;

ii. Pertinent history obtained;

iii. Pertinent physical findings, including pertinent negative physical findings based on (a)i and ii above;

iv. The procedures, if any, with results;

v. Laboratory, X-ray, EKG, etc., ordered with results; and

vi. The diagnosis(es).

2. In a hospital or nursing facility setting:

i. An update of symptoms;

ii. An update of physical symptoms;

iii. A resume of findings of procedures, if any done;

iv. Pertinent positive and negative findings of lab, X-ray;

v. Additional planned studies, if any, and why; and

vi. Treatment changes, if any.

10:58-1.12 Recordkeeping; hospital inpatient stay

(a) To qualify as documentation that the service was rendered by the practitioner during a hospital inpatient stay, the medical record shall contain the CNM's notes, indicating that the practitioner personally:

1. Reviewed the patient's medical history with the patient and/or his or her family, depending upon the medical situation;

2. Performed an examination as appropriate;

3. Confirmed or revised the diagnosis; and

4. Visited and examined the patient on the days for which a claim for reimbursement is made.

10:58-1.13 Recordkeeping; preventive medicine services; annual health maintenance examination

(a) For individuals under 21 years of age, the following shall be performed and documented in the beneficiary's record:

1. A history (complete initial for new patient, interval for established patient) including past medical history, family history, social history, and systemic review;

2. A developmental and nutritional assessment;

3. A complete, unclothed, physical examination to also include the following:

i. Measurements, including: height and weight; head circumference to 25 months; blood pressure for children age three years or older; and

ii. Vision and hearing screening;

4. An assessment and administration of immunizations appropriate for age and need, as determined by medical practice and professional medical judgment, in accordance with 42 U.S.C. § 1396s and N.J.A.C. 10:58-3;

5. Provisions for further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected;

6. Referral to a dentist for children age three years or older;

7. Laboratory procedures performed or referred if medically necessary. Recommendations are:

i. Hemoglobin/Hematocrit: 10 to 12 years;

ii. Urinalysis: 13 to 18 years;

iii. Tuberculin test (Mantoux) annually;

iv. Lead screening using blood level determinations shall be performed between six and 12 months, at two years of age, and annually up to six years of age. At all other visits, screening shall consist of verbal risk assessment and blood lead level test, as indicated; and

v. Other appropriate screening procedures, if medically necessary, (for example: blood cholesterol, test for ova and parasites, STD);

8. Health education and anticipatory guidance; and

9. An offer of social service assistance; and, if requested, referral to a county board of social services (CBOSS).

10:58-1.14 Recordkeeping; home visit or house call

(a) The record and documentation of a home visit or house call shall become part of the office progress notes and shall include, as appropriate, the following information:

1. The purpose of the visit;

2. The pertinent history obtained;

3. Pertinent physical findings, including pertinent negative physical findings based on (a)1 and 2 above;

4. The procedures, if any performed, with results;

5. Laboratory, X-ray, ECG, etc., ordered with results; and

6. The diagnosis(es) plus treatment plan status relative to present or pre- existing illness(es) plus pertinent recommendations and actions.

10:58-1.15 Recordkeeping requirements for birth center services

(a) Medical records maintained by a birth center for the maternity services shall include, but not be limited to:

1. Patient identification;

2. An initial medical history, results of physical examination, and diagnosis;

3. Progress notes for each visit, which shall include interim history, physical findings, and disposition;

4. Reports of laboratory and other diagnostic studies, and consultation;

5. Any allergies and abnormal drug reactions;

6. A report of the delivery process;

7. The status and condition of the newborn;

8. Documentation of properly executed informed consent of each woman enrolling in a birth center for treatment; and

9. A discharge diagnosis.

END OF SUBCHAPTER 1

SUBCHAPTER 2. PROVISIONS FOR SPECIFIC SERVICES

10:58-2.1 Evaluation and management services (HCPCS)

(a) Evaluation and management services HCPCS procedure codes are used to indicate certain services performed in a CNM's independent practice.

(b) Reimbursement for an initial office visit will be disallowed if a preventive medicine service visit, EPSDT examination visit or office consultation were billed within a 12-month period by the same practitioner, group of practitioners, or shared health care facility sharing a common record.

10:58-2.2 Evaluation and management: initial visits

(a) For office visits and for other care apart from inpatient hospital, CNMs shall bill for an initial visit only once for a specific patient, subject to the exceptions contained in (b) below. When a shared health care facility, a group of physicians and/or other practitioners (CNMs) share a common record, the Division will reimburse only one initial visit. Further encounters with that patient will be billed and reimbursed by means of "established patient" codes. (See N.J.A.C. 10:58-3.1 through 3.5.)

(b) In the inpatient hospital setting, the initial visit concept still applies for reimbursement purposes, except that subsequent readmissions to the same facility may be designated as initial visits as long as a time interval of 30 days or more has elapsed between admissions.

(c) An initial hospital visit will be disallowed to the same practitioner, group of practitioners, shared health care facility, or practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service.

(d) In order to use the HCPCS procedure code to bill for an initial visit, the CNM shall provide the minimal documentation in the record regardless of the setting where the examination was performed. See N.J.A.C. 10:58-1.8(c).

10:58-2.3 Evaluation and management: office or other outpatient services (established patient); or subsequent hospital care

Office or other outpatient service, or subsequent hospital care visits shall conform to the CPT description of provider involvement and time. The setting could be office or hospital. The documentation requirements for these visits are found in N.J.A.C. 10:58-1.9.

10:58-2.4 Evaluation and management: preventive medicine

(a) In the absence of patient complaints, the procedure codes identified as preventive medicine services shall be used for adults and for children.

(b) Preventive medicine services codes (new patient) are comparable, in respect to reimbursement level, to an initial visit and, therefore, shall only be billed once per patient, per year. These codes shall be denied when the beneficiary is seen by the same practitioner, group of practitioners, or involves a shared health care facility sharing a common record. Preventive visits (established patient) for adults shall be considered an annual health maintenance visit.

(c) Requirements for preventive medicine services, the annual health maintenance examination, for new or established patients under the age of 21 are as follows:

1. These codes are not allowable for payment when used following an EPSDT examination performed within the preceding 12 months for a child older than two years of age; and

2. Preventive medicine codes may be used in accordance with the periodicity schedule of preventive visits recommended by the American Academy of Pediatrics. (See N.J.A.C. 10:58-2.8 through 2.12.)

10:58-2.5 Evaluation and management: consultations requested by CNMs

(a) A consultation shall be reimbursed by the New Jersey Medicaid/NJ FamilyCare fee-for-service programs when performed by a physician specialist (other than her collaborating physician) recognized as such by the Medicaid/NJ FamilyCare programs

and when the request is made by or through the patient's CNM. The need for such a request shall be consistent with good medical practice.

(b) When the CNM needs to refer the patient(s) for consultation or for other services, the provider of the consultation or other service shall bill the New Jersey Medicaid/NJ FamilyCare-Plan A fee-for-service programs directly and shall be reimbursed directly for the consultation or referred service.

10:58-2.6 Evaluation and management: CNM home services and house calls

(a) The home services recognized as "house calls" refer to a practitioner visit to an individual who would be too ill to go to a practitioner's office and/or is "home bound," as determined by the attending physician, due to his or her physical condition. CNMs shall be reimbursed for house calls.

(b) For purposes of Medicaid/NJ FamilyCare-Plan A fee-for-service reimbursement, "home visits" apply when the provider visits Medicaid/NJ FamilyCare-Plan A fee-for-service beneficiaries who do not qualify as "home bound." CNMs are not reimbursed for home visits.

10:58-2.7 Evaluation and management: emergency department and inpatient hospital services

(a) When a practitioner sees the patient in the emergency room instead of his or her office, the practitioner shall use the same codes for the visit that would have been used if seen in the practitioner's office. Records of that visit shall become part of the notes in the office chart.

(b) When patients are seen by hospital-based emergency room practitioners who are eligible to bill the Medicaid/NJ FamilyCare-Plan A fee-for-service programs, the appropriate HCPCS code is used. These "visit" codes are listed at N.J.A.C. 10:58-3.2.

(c) Critical care/prolonged services shall be covered when the patient's situation requires constant practitioner attendance which is given by the practitioner to the exclusion of her other patients and duties, and therefore represents what is beyond the usual service for the practitioner.

1. The critical care/prolonged services code shall not apply to monitoring pregnant women in labor.

2. Critical care/prolonged service shall be documented in the applicable records, as defined by the setting. The records shall show, in the practitioner's handwriting, the time of onset and time of completion of the service. Settings that are applicable are the office, hospital, or home.

3. The reimbursement for the "critical care" or prolonged services utilizes the time parameter, and is all-inclusive, meaning that it shall be the only payment for care provided by the practitioner to the patient at that time. The specific procedures performed during that patient encounter shall not be reimbursed in addition to the "critical care/prolonged services" payment.

10:58-2.8 Early and Periodic Screening, Diagnosis and Treatment (EPSDT); general

(a) The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a comprehensive health program for Medicaid/NJ FamilyCare beneficiaries from birth through 20 years of age. The goal of the program is to assess the beneficiary's health needs through initial and periodic examinations (screenings); to provide health education and guidance; and to assure that health problems are prevented or diagnosed and treated at the earliest possible time.

(b) For the certification criteria that a physician must meet in providing services to children under 21 years of age, see N.J.A.C. 10:54-1.5, concerning certification of physician services.

(c) As a condition of participation in Medicaid/NJ FamilyCare, all ambulatory care facilities (including hospital outpatient departments) providing primary care to children and adolescents from birth through 20 years of age, shall participate in the EPSDT program and shall provide, at a minimum, the required EPSDT screening services.

(d) EPSDT services shall include the following:

1. Screening services;

2. Vision services;

3. Dental services;

4. Hearing services; and

5. Other medically necessary health care, diagnostic services and treatment and other measures to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.

(e) EPSDT screening services, vision services, dental services, and hearing services shall be provided at defined intervals as required by the standards contained in N.J.A.C. 10:58-3.

(f) EPSDT screening services shall include the following components:

1. A comprehensive health and developmental history including an assessment of both physical and mental health development;

2. Developmental assessment shall be culturally sensitive and valid. The parameters used in assessing the beneficiary's developmental level and behavior shall be appropriate for the age. While no specific test instrument is endorsed, it is expected that an evaluation of a young child shall, at a minimum, address the gross and fine motor coordination, language/vocabulary and adaptive behavior including self-help and self-care skills and social emotional development. An assessment of a school age child shall include school performance; peer relationships; social activity and/or behavior; physical and/or athletic aptitude; and sexual maturation.

3. A comprehensive unclothed physical examination, including vision and hearing screening, dental inspection and nutritional assessment;

4. Appropriate immunizations according to age and health history;

5. Appropriate laboratory tests, including:

i. Hemoglobin or hematocrit;

ii. Urinalysis;

iii. Tuberculin skin test (Mantoux), intradermal, administered annually and when medically indicated;

iv. Lead screening using blood lead level determinations between six and 12 months, at two years of age, and annually up to six years of age. At all other visits, screening

shall consist of verbal risk assessment and blood lead level testing, as indicated;

v. Additional laboratory tests which may be appropriate and medically indicated (for example, for ova and parasites) shall be obtained, as necessary;

6. Health education, including anticipatory guidance;

7. Referral for further diagnosis and treatment or follow-up of all correctable abnormalities, uncovered or suspected. Referral may be made to the provider conducting the screening examination or to another provider, as appropriate; and

8. Referral to the Special Supplemental Food program for Women, Infants and Children (WIC) for children under five years of age and for pregnant or lactating women.

(g) EPSDT screening services shall be provided periodically according to the following schedule which reflects the age of the child:

1. Under six weeks; two months; four months; six months; nine months; 12 months; 15 months; 18 months; 24 months; and annually through age 20 years.

(h) Vision screening shall include the following:

1. A newborn examination, including general inspection of the eyes, visualization of the red reflex and evaluation of ocular motility;

2. A medical and family history which is appropriate for the individual patient;

3. An evaluation, by age six months, of eye fixation preference, muscle imbalance, and pupillary light reflex;

4. A third examination with visual acuity testing by age three or four years; and

5. Periodicity testing for school aged children, as follows:

i. Kindergarten or first grade (five or six years);

ii. Second grade (seven years);

iii. Fifth grade (10/11 years);

iv. Eighth grade (13/14 years); and

v. Tenth or eleventh grades (15/17 years).

(i) Children shall be referred for further vision testing if they:

1. Cannot read the majority of the 20/40 line before their fifth birthday;

2. Have a two-line difference of visual acuity between the eyes;

3. Have suspected strabismus; or

4. Have an abnormal light or red reflex.

(j) Dental screening shall include the following:

1. An intraoral examination which is an integral part of a general physical examination, meaning observation of tooth eruption, occlusion pattern, and presence of caries or oral infection;

2. A formal referral to a dentist, which is recommended at one year of age; and is mandatory for children three years of age and older; and

3. Dental inspection and prophylaxis, which should be carried out every six months until 17 years of age, then annually.

(k) Hearing screening requirements shall include the following:

1. An individual hearing screening shall be administered annually to all children through age eight, and to all children who are at risk of hearing impairment;

2. In addition to what is required in (k)1 above, after eight years of age, children shall be screened every other year; and

3. Hearing screening shall include, at a minimum, an observation of an infant's response to auditory stimuli. Speech and hearing assessment shall be part of each preventive visit for an older child. An objective audiometric test, such as a pure tone screening test, if performed as part of an EPSDT screening examination, is eligible for separate reimbursement.

10:58-2.9 Clinical laboratory services; general

(a) Clinical laboratory services shall be furnished by clinical laboratories and by provider office laboratories (POLs) that meet the Health Care Financing Administration regulations pertaining to clinical laboratory services (Section 1902(a)9 of the Social Security Act; 42 U.S.C. 1396(a)9; 42 C.F.R. 440.30 and 493) defined in the Clinical Laboratory Improvement Amendments (CLIA) of 1988 (P.L. 100-518), and as indicated at N.J.A.C. 10:61-2.1, the Medicaid/NJ FamilyCare programs' Independent Clinical Laboratory Services Manual (N.J.A.C. 10:61) and N.J.A.C. 8:44 and 8:45.

(b) All independent clinical laboratories and other entities performing clinical laboratory testing for Medicaid/NJ FamilyCare-Plan A fee-for-service beneficiaries must meet the requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. These requirements include that the provider must have one of the following certificates; as required by 42 C.F.R. 493:

1. A certificate of waiver;

2. A certificate of compliance;

3. A registration certificate;

4. A certificate for provider-performed microscopy (PPM) procedures;

5. A certificate of accreditation, and a registration certificate or a certificate of compliance; or

6. Be CLIA exempt due to accreditation by a private nonprofit accreditation organization or exempted under an approved state laboratory program.

10:58-2.10 Clinical laboratory services provided by a CNM

(a) A CNM may claim reimbursement for clinical laboratory services performed for his or her own patients within his or her own office, except when provided in a birth center. Laboratory services provided in a birth center shall be billed to Medicaid/NJ FamilyCare-Plan A fee-for-service programs by the center.

1. A CNM shall meet the conditions of the CLIA regulations before she or he may perform clinical laboratory testing for Medicaid/NJ FamilyCare-Plan A fee- for-service beneficiaries; and

2. The clinical laboratory tests shall be standard clinical laboratory procedures consistent with the CNM's CLIA certification, certificate of waiver or certificate of registration.

(b) Profiles are components of a test or series of tests which are frequently performed or automated. Examples of identifiable laboratory profiles or studies are as follow:

1. Obstetrical Profile;

2. The components of an SMA (Sequential Multichannel Automated Analysis) 12/60 or other automated laboratory study; or

3. Inclusion of blood indices, such as MCH (Mean Corpuscular Hemoglobin), MCV (Mean Corpuscular Volume), as a component of a CBC (Complete Blood Count).

(c) If the components of a profile are billed separately, reimbursement for the components of the profile (panel) shall not exceed the Medicaid fee allowance for the profile itself.

10:58-2.11 Clinical laboratory services; venipuncture

(a) When any part of the clinical laboratory test(s) is performed on site, the venipuncture is not reimbursable as a separate procedure: its cost is included within the reimbursement for the laboratory procedure. Venipuncture is reimbursable if the total specimen is referred to the independent clinical laboratory.

10:58-2.12 Clinical laboratory services; CNM referral to independent laboratory

(a) When the CNM refers a laboratory test to an independent clinical reference laboratory:

1. The clinical reference laboratory shall be certified under CLIA requirements to perform the required laboratory test(s) (see Section 1902(a)9 of the Social Security Act; 42 U.S.C. 1396a(a)9; 42 C.F.R. 440.30, 493);

2. The clinical laboratory shall be licensed by the New Jersey State Department of Health and Senior Services in accordance with N.J.A.C. 8:44 and 8:45, or comparable agency in the state in which the laboratory is located; and

3. The clinical laboratory shall be approved for participation as an independent

laboratory provider by the New Jersey Medicaid/NJ FamilyCare-Plan A fee-for-service programs.

(b) Independent clinical laboratories shall bill the New Jersey Medicaid/NJ FamilyCare-Plan A fee-for-service programs for all reference laboratory work performed on their premises. The CNM will not be reimbursed for laboratory work performed by a reference laboratory.

10:58-2.13 Clinical laboratory services; rebates

Rebates by reference laboratories, service laboratories, physicians or other utilizers or providers of laboratory services are prohibited under the New Jersey Medicaid/NJ FamilyCare programs. This refers to rebates in the form of refunds, discounts or kickbacks, whether in the form of money, supplies, equipment, or other things of value. This provision prohibits laboratories from renting space from or providing personnel or other considerations to a physician or other practitioner whether or not a rebate is involved.

10:58-2.14 Family planning services; general

(a) Family planning services may be provided by the CNM, including medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling.

(b) Services provided primarily for the diagnosis and treatment of infertility, including related office visits, drugs, laboratory services, radiological and diagnostic services and surgical procedures, are not covered by the New Jersey Medicaid/NJ FamilyCare programs, except when a service is provided that is ordinarily considered an infertility service, but is provided for another purpose. The certified nurse midwife shall submit the claim for that service, with supporting documentation, for medical review and approval of payment to the Division of Medical Assistance and Health Services, Office of Utilization Management, Mail Code #14, PO Box 712, Trenton, NJ 08625-0712.

10:58-2.15 Family planning services; Norplant System (NPS)

(a) The Norplant System (NPS) is a Medicaid/NJ FamilyCare covered service when provided as follows:

1. The NPS is used only in reproductive age women with established regular menstrual cycles;

2. The Food and Drug Administration (FDA)-approved physician prescribing information is followed; and

3. Patient education and counseling are provided relating to the NPS, including pre and post-insertion instructions, indications, contraindications, benefits, risks, side effects, and other contraceptive modalities.

(b) A CNM shall not be reimbursed separately for an office visit when that visit was solely for the purpose of the insertion or removal of an NPS device. A CNM shall be reimbursed for the NPS device and the insertion and/or removal of the appropriate procedure codes related to the NPS system (see N.J.A.C. 10:58-3.6(a)).

(c) Only two insertions and two removals of the NPS per beneficiary shall be reimbursed during a five-year continuous period.

(d) The CNM shall not be reimbursed for the NPS in conjunction with other forms of contraception, for example, intrauterine device.

10:58-2.16 HealthStart maternity and pediatric services

(a) The purpose of HealthStart is to provide comprehensive maternity and child health care services for all pregnant women (including those determined to be presumptively eligible) and for children (under two years of age) in the State of New Jersey who are eligible for Medicaid benefits. For reimbursement for certified nurse midwives billing independently, refer to N.J.A.C. 10:58-3.2 and 3.5. For other requirements regarding HealthStart in any setting, refer to the Independent Clinic Services chapter, N.J.A.C. 10:66-3. The CNM shall not become a HealthStart Pediatric Care provider. The CNM shall be an EPSDT provider for adolescent Medicaid recipients. (See N.J.A.C. 10:58-2.2 for EPSDT services.)

(b) Separate reimbursement is available for HealthStart Maternity Care and Health Support Services procedure codes.

(c) Maternity medical care services should be billed as a total obstetrical package, when feasible, but may be billed as separate procedures.

(d) The enhanced reimbursement for the delivery and postpartum care may be claimed only for a patient who had received at least one antepartum HealthStart Maternity Care visit and had at least one health support services visit.

(e) The modifier "WM" accompanying any given procedure code in the HCPCS list of codes refers to those services provided by CNM and the modifier shall be included at the end of each code when billing for CNM services.

10:58-2.17 Pharmaceutical services; drugs prescribed and administered by a CNM

(a) All covered pharmaceutical services provided under the New Jersey Medicaid/NJ FamilyCare programs shall be provided to Medicaid/NJ FamilyCare- Plan A fee-for-service beneficiaries within the scope of N.J.A.C. 10:49, Administration chapter; N.J.A.C. 10:51, Pharmaceutical Services; and N.J.A.C. 10:58, Certified Nurse Midwifery Services.

(b) All drugs shall be prescribed drugs. (See definition of "prescribed drugs" in N.J.A.C. 10:58-1.3.)

(c) The New Jersey Medicaid/NJ FamilyCare programs shall reimburse Medicaid/NJ FamilyCare participating pharmacies for pharmaceutical services prescribed by the certified nurse midwife if all the requirements of the New Jersey Medicaid/NJ FamilyCare-Plan A fee-for-service programs for pharmaceutical services are met.

(d) The following requirements shall be met for the following services:

Service	Requirement
Covered pharmaceutical services	N.J.A.C. 10:51-1.11
Prior-authorized services	N.J.A.C. 10:51-1.13
Quantity of medication dispensed	N.J.A.C. 10:51-1.14
Dosage and directions	N.J.A.C. 10:51-1.15
Telephone-rendered original prescription	N.J.A.C. 10:51-1.16
Changes or additions to the original prescription	N.J.A.C. 10:51-1.17
Prescription refill	N.J.A.C. 10:51-1.18
Prescription Drug Price and Quality Stabilization Act	N.J.A.C. 10:51-1.19
Non-proprietary or generic dispensing	N.J.A.C. 10:51-1.9
Drug Efficacy Study Implementation (DESI)	N.J.A.C. 10:51-1.20
	N.J.A.C. 10:51, Appendix A
Drug Manufacturers' Rebate Agreement	N.J.A.C. 10:51-1.21

(e) Diabetic testing materials, including blood glucose reagent strips, urine monitoring strips, tapes, tablets, and lancets, may also be reimbursed. Electronic blood glucose monitoring devices or other devices used in the monitoring of blood glucose levels are considered medical supplies and are covered services by the Medicaid/NJ FamilyCare-Plan A fee-for service programs if they meet all applicable requirements of the New Jersey Medicaid/NJ FamilyCare programs. These services may require prior

authorization from the Medicaid District Office (MDO). (See Medical Supplier Services Chapter, N.J.A.C. 10:59.)

(f) The New Jersey Medicaid/NJ FamilyCare fee-for-service programs shall reimburse the certified nurse midwife for certain approved drugs administered by inhalation, intradermally, subcutaneously, intramuscularly or intravenously in the office or home, as follows:

1. Certified nurse midwife-administered medications shall be reimbursed directly to the certified nurse midwife under certain situations. (See N.J.A.C. 10:58-3 for a listing of HCPCS procedure codes, "J" codes and applicable 3rd level procedure codes.)

i. An office or home visit (when the criteria for an office or home visit is met) and the procedure code for the method of drug administration may be billed in conjunction with a "J" code. The HCPCS 90782, 90784, 90785 and 90799 may be billed for intradermal, subcutaneous, intramuscular, or intravenous drug administration, respectively.

ii. The New Jersey Medicaid/NJ FamilyCare programs have assigned HCPCS procedure codes and maximum fee allowances at N.J.A.C. 10:58-3.4 and 3.5 for specific drugs. Reimbursement to the certified nurse midwife for these specific drugs shall be based on the Average Wholesale Price (AWP) of a single dose of an injectable or inhalation drug, or the CNM's acquisition cost, whichever is less.

iii. Unless otherwise indicated in N.J.A.C. 10:58-3, or (f)1iv through vii below, the Medicaid/NJ FamilyCare fee-for-service maximum fee allowance is determined based on the AWP per unit which equals one cubic centimeter (cc) or milliliter (ml) of drug volume for each unit. For drug vials with a volume equal to one cubic centimeter (cc) or milliliter (ml), the Medicaid/NJ FamilyCare fee-for-service maximum fee allowance shall be based on the cost per vial.

iv. When a certified nurse midwife office or home visit is made for the sole purpose of administering a drug, reimbursement shall be limited to the cost of the drug and its administration. In these situations, there is no reimbursement for a certified nurse midwife's office or home visit. If, in addition to the certified nurse midwife's administration of a drug, the criteria of an office or home visit are met, the cost of the drug and administration may, if medically indicated, be reimbursed in addition to the visit.

v. No reimbursement will be made for vitamins, liver or iron injections or combination thereof, except in laboratory-proven deficiency states requiring parenteral therapy.

vi. No reimbursement will be made for drugs or vaccines supplied free to the CNM, for

placebos, or for any injections containing amphetamines or derivatives thereof.

vii. No reimbursement will be made for injection given as a preoperative medication or as a local anesthetic which is part of an operative or surgical procedure, since this injection would normally be included in the prescribed fee for such a procedure.

2. When a drug required for administration has not been assigned a "J" code or Level III HCPCS procedure code, the drug shall be prescribed and obtained from a pharmacy which directly bills the New Jersey Medicaid/NJ FamilyCare fee-for-service programs. In this situation, the certified nurse midwife shall bill only for the administration of the drug using HCPCS 90782, 90784, 90788 and 90799.

3. Reimbursement for immunization procedure codes includes the cost of the administration of the immunization.

(g) The drug administered must be consistent with the diagnosis and conform to accepted medical and pharmacological principles in respect to dosage frequency and route of administration.

(h) For Hepatitis B vaccine, coverage is available for post exposure prophylaxis and for vaccination of individuals in selected high risk groups, regardless of age, in accordance with the criteria defined by the Centers for Disease Control. In all cases, the need for this vaccination shall be fully documented in the medical record by the certified nurse midwife. (See N.J.A.C. 10:58-3.5 and 3.6, respectively, for specific descriptions and qualifiers associated with each Level III procedure code.)

10:58-2.18 Birth center facility services

(a) Birth center facility services shall include, but not be limited to, administrative, nursing, and technical services related to labor and delivery.

(b) Other services and items not directly related to the care of the patient, such as guest meals and accommodations, televisions, telephones, and similar items, are non-covered services that shall not be eligible for payment by the Division. These services and other personal items may be billed to the patient directly, provided the patient is informed and agrees to accept responsibility for personal items.

(c) Physician services provided in birth centers shall be considered as professional physician services, in accordance with N.J.A.C. 10:54. Physician services shall be reimbursed using a separate physician Medicaid/NJ FamilyCare provider number and

appropriate procedure codes, in accordance with N.J.A.C. 10:54.

END OF SUBCHAPTER 2

SUBCHAPTER 3. HEALTH CARE FINANCING ADMINISTRATION (HCFA) COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:58-3.1 Introduction

(a) The New Jersey Medicaid/NJ FamilyCare programs utilize the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). HCPCS follows the American Medical Association's Physicians' Current Procedural Terminology (CPT) (American Medical Association, PO Box 10950, Chicago, Illinois 60610, Attention: Order Department) using the architecture employing a five-position code and as many as two-position modifiers. Unlike the CPT numeric design, the HCFA assigned codes and modifiers contain one alphabetic character and four numeric characters. HCPCS was developed as a three-level coding system.

1. Level I Codes (Narratives found in CPT): CPT is a listing of numeric identifying codes and modifiers, and descriptive terms for reporting medical services and procedures performed by physicians.

2. Level II Codes (Narratives found in N.J.A.C. 10:58-3.4): These codes are not found in CPT and are assigned by HCFA for physician, practitioner, and non-physician services.

3. Level III Codes (Narratives found in N.J.A.C. 10:58-3.5): These codes are assigned by the Division of Medical Assistance and Health Services to be used for those services which are unique to the New Jersey Medicaid/NJ FamilyCare programs.

(b) Listed below are some of the general policies of the New Jersey Medicaid/NJ FamilyCare programs relevant to HCPCS. (The responsibility of the CNM when rendering specific services and requesting reimbursement is listed in N.J.A.C. 10:58-1.)

1. When filing a claim, the HCPCS procedure codes, including modifiers, must be used in accordance with the narratives in the CPT or N.J.A.C. 10:58- 3.3, 3.4 and 3.5, whichever is applicable.

2. The use of a procedure code will be interpreted by the New Jersey Medicaid/NJ FamilyCare programs as evidence that the CNM personally furnished, as a minimum, the stated service.

10:58-3.2 Elements of HCPCS Procedure Codes which require attention of the certified nurse midwife

(a) The list of HCPCS procedure codes for nurse midwifery services are arranged in tabular form with specific information for a code given under columns with titles such as: "IND," "HCPCS CODE," "MOD," "DESCRIPTION," "FOLLOW-UP DAYS," "MAXIMUM FEE ALLOWANCE SCHEDULE" and "ANESTHESIA BASIC UNITS." The information given under each column is summarized below:

Column Title

"IND" (Indicator-Qualifier) Lists alphabetic symbols used to refer a provider to information concerning the New Jersey Medicaid/ NJ FamilyCare programs' qualifications and requirements when a HCPCS procedure code is used.

Explanation of indicators and qualifiers used in this column are given below:

"N" Preceding any procedure code means that qualifiers are applicable to that code.

"HCPCS CODES"--Lists the HCPCS procedure codes.

"MOD" Lists alphabetic and numeric symbols. Services and procedures may be modified under certain circumstances. When applicable, the modifying circumstance is identified by the addition of alphabetic and/or numeric characters affixed to the code. The modifiers are as follow:

"WM" Midwifery: Used to identify procedures performed by CNM by adding the modifier "WM" to the procedure code.

"22" Unusual Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by affixing "22" after the usual procedure number.

"52" Reduced Services: Under certain circumstances, a service or procedure is partially reduced or eliminated. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier "52", signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

"DESCRIPTION"--Lists the code narrative for Level II and III codes. Narratives for Level I codes are found in the CPT.

"FOLLOW-UP"--Lists the number of days for follow-up.

"MAXIMUM FEE ALLOWANCE"--Lists the New Jersey Medicaid/NJ FamilyCare programs'

reimbursement schedule for nurse midwifery services.
"ANESTHESIA BASIC UNITS"--B.U.V. (Basic Unit Value)

1. These symbols when listed under the "IND" and "MOD" columns are elements of the HCPCS coding system used as qualifiers or indicators (as in the "IND" column) and as modifiers (as in the "MOD" column). They assist the CNM in determining the appropriate procedure codes to be used, the area to be covered, the minimum requirements needed, and any additional parameters required to be eligible for reimbursement.

i. These symbols and/or letters must not be ignored, because in certain instances there are requirements in addition to the narrative, which accompanies the HCPCS procedure code as described in the CPT. The CNM is responsible for all the requirements and not just the code narrative as described in the CPT. All the described requirements in the CPT must be fulfilled in order to be eligible for reimbursement.

10:58-3.3 HCPCS Procedure Codes (Level 1) and maximum fee allowance schedule for nurse midwifery services

IND	HCPCS Codes	Mod	Follow Up Days	Max. Fee Allowance	Anesthesia Basic Units
N	11975	WM	30	80.70	
N	11975	WM22	30	80.70 plus Direct Package price	
N	11976	WM	90	80.70	
N	11977	WM	90	161.50	
N	11977	WM22	90	161.50 plus Direct Package price	
N	36415	0		1.80	0
N	58301	WM	0	16.40	0
N	59400	WM	60	328.00	4
N	59409	WM	60	210.00	4
N	59410	WM	60	224.00	4
N	59430	WM	0	14.00	0
N	80055			15.00	
	81000			1.20	
	81002			1.00	
	81007			3.82	
	82044			1.00	
	82948			1.50	

	83986			4.30		
	84703			3.00		
	85013			1.50		
N	85014			1.50		
N	85018			1.20		
	86580			4.00		
	86585			4.00		
	90702			3.29		
	90702	52		2.50		
	90706			22.04		
	90706	52		2.50		
	90707			39.87		
	90707	52		2.50		
	90724			6.97		
	90724	52		2.50		
	90732			14.35		
	90732	52		2.50		
N	90741			BR		
	90741	52		2.50		
N	90742			BR		
	90742	52		2.50		
	90746			63.57		
	+ 90746	52		2.50		
N	90780			40.00 per hour		
N	90781			40.00 per hour		
N	99201	WM	0	11.20	0	
N	99202	WM	0	11.20	0	
N	99203	WM	0	13.60	0	
N	99204	WM	0	13.60	0	
N	99211	WM	0	11.20	0	
N	99212	WM	0	11.20	0	
N	99213	WM	0	11.20	0	
N	99214	WM	0	11.20	0	
N	99215	WM	0	11.20	0	
N	99221	WM	0	13.60	0	
N	99231	WM	0	11.20	0	
N	99232	WM	0	11.20	0	
N	99341	WM	0	11.20	0	
N	99342	WM	0	11.200		
N	99351	WM	0	11.20	0	
N	99352	WM	0	11.20	0	
N	99384	WM	0	13.60	0	

N	99385	WM	0	13.60	0
N	99386	WM	0	13.60	0
N	99387	WM	0	13.60	0
N	99394	WM	0	13.60	0
N	99395	WM	0	13.60	0
N	99396	WM	0	13.60	0
N	99397	WM	0	13.60	0

+ This is a Level II code, which is included here for the convenience of the providers. This code is for the administration of the vaccine only and applies only to beneficiaries over the age of 19.

10:58-3.4 HCPCS Procedure Codes (Level II) and maximum fee allowance schedule for certified nurse midwifery services

HCPCS Codes	Descriptions	Maximum Fee Allowance
J2790	RhoGAM, Rho (D) Immune Globulin (Human) Single dose (Micro-Dose)	$26.00
J2790 22	RhoGAM, Rho (D) Immune Globulin (Human) Single dose (Full dose) (22--Services greater than usual)	$45.00
J1050	Medroxyprogesterone acetate, 100 mg	9.05
J1055	Medroxyprogesterone acetate for contraceptive use, 150 mg	44.54

10:58-3.5 HCPCS Procedure Codes (Level III) and maximum fee allowance schedule for certified nurse midwifery services

IND	HCPCS Codes	MOD	Follow-up Days	Descriptions	Maximum Fee Allowance
(a) Intrauterine Devices:					
	W0001	WM	30	Supplying and inserting the intrauterine device "Paragard" by a CNM including the post-insertion visit.	$304.00
	W0002	WM	30	Supplying and inserting the intrauterine device "Progestasert" by a CNM including the post-insertion visit.	$137.00
	W0004	WM	30	Removal of an IUD by a CNM followed at the same visit by the insertion of the intrauterine device "Paragard" by a CNM including the post-insertion visit.	$317.00
	W0008	WM	30	Removal of an IUD by a CNM followed at the same visit by the insertion of the intrauterine device "Progestasert" by a CNM including the post-insertion visit.	$150.00
(b) HealthStart:					
N	W9025	WM		HealthStart Initial Antepartum Maternity Medical Care Visit by Certified Nurse Midwife	67.00
N	W9026	WM		HealthStart Subsequent Antepartum Maternity Medical Care Visit by Certified Nurse Midwife	19.00
N	W9027	WM		HealthStart Regular Delivery by Certified Nurse Midwife	371.00
N	W9028	WM		HealthStart Postpartum Care Visit by Certified Nurse Midwife	19.00
N	W9029	WM		HealthStart Regular Delivery and Postpartum Visit by Certified Nurse Midwife	390.00
N	W9030	WM		HealthStart Total Obstetrical Care by Certified Nurse Midwife	723.00
(c) Injections:					

N	W9098		Hepatitis B immunoprophylaxis with Recombivax HB, 0.5 ml dose. This code applies only to high risk beneficiaries who are 19 years of age.	32.79
	W9098	52	Administration of vaccine only.	2.50
N	W9335		Hepatitis B immunoprophylaxis with Engerix-B, 1.0 ml dose. This code applies only to high risk beneficiaries over 18 years of age.	62.09
	W9335	52	Administration of vaccine only	2.50
	W9337		Cephradine 250 mg	2.34
	W9356		Vaccine for Children Administration Fee	$11.50

(d) EPSDT:

N	W9820	WM	Early and Periodic Screening, Diagnosis and Treatment (EPSDT) from 2 through 20 years of age	18.00

(e) Maternity Care:

N	W9855	WM	Initial Visit Antepartum Visit by Certified Nurse Midwife	15.40
N	W9856	WM	Subsequent Antepartum Visit by Certified Nurse Midwife	11.20

(f) Delivery Services:

	Z0250	WM	Home Delivery Pack (All drugs and supplies, etc. necessary for delivery in this setting.)	40.00

(g) Birth Centers Facility Fee:

	W9858	Birth Center Services, global	1,300.00
	W9859	Birth Center Services, limited	500.00

10:58-3.6 HCPCS codes qualifiers for certified nurse midwifery services

(a) Surgical services: Norplant System (NPS)

11975 WM QUALIFIER: Reimbursed for the insertion and reinsertion of the Norplant System (six Levonorgestrel Implants) and the post-insertion visit when provided in a hospital setting, when the CNM bills for the service. When using this procedure code, the CNM will not be reimbursed for the cost of the kit. The supplier of the kit to the CNM will be either reimbursed by the

hospital or be reimbursed directly for the cost of the kit.

11975 WM 22 QUALIFIER: The maximum fee allowance includes the cost of the kit supplied to the CNM, the insertion of the Norplant System (six Levonorgestrel Implants), and the post-insertion visit. NOTE: The "22" modifier indicates the inclusion of the cost of the kit.

11976 WM QUALIFIER: The maximum fee allowance is reimbursed for the removal of the Norplant System (six Levonorgestrel Implants) and the post-removal visit.

11977 WM QUALIFIER: The maximum fee allowance is reimbursed for the removal and reinsertion of the Norplant System (six Levonorgestrel Implants) and the post-removal/reinsertion visit.

11977 WM 22 QUALIFIER: The maximum feeallowance is reimbursed for the removal and reinsertion of the "Norplant System" (six Levonorgestrel Implants) and for the post-removal/reinsertion visit. NOTE: Modifier "22" indicates that the billing includes the cost of the NPS kit.

(b) Laboratory services:

36415 QUALIFIER: Once per visit, per patient. Not applicable if laboratory study, in any part, is performed by the office staff of the CNM or by CNM herself. When the clinical laboratory test is performed on site, the venipuncture is not reimbursable as a separate procedure; its cost is included within the reimbursement for the laboratory procedure.

(c) Immunization:

W9098 QUALIFIER: This code applies only to high risk beneficiaries who are 19 years of age.

W9335 QUALIFIER: This code applies only to high risk beneficiaries who are over 18 years of age.

90741 QUALIFIER: Prior authorization form the Medical Consultant at the Medicaid District Office is required.

90742 QUALIFIER: Prior authorization from the Medical Consultant at the Medicaid District Office is required.

(d) Infusion therapy (excluding allergy, immunization and chemotherapy):

90780 QUALIFIER: Not to be used for routine IV drug injection or infusion. Reimbursement is contingent upon the required medical

necessity, and written chart documentation, including time and the indication of the CNM's presence with the patient to the exclusion of her other duties.

90781 QUALIFIER: Not to be used for routine IV drug injection or infusion. Reimbursement is contingent upon the required medical necessity, and written chart documentation, including time and the indication of the CNM's presence with the patient to the exclusion of her other duties.

(e) Evaluation and management services:

For policy related to qualifiers for the following codes, see N.J.A.C. 10:58-2.3. (99201WM, 99202WM, 99203WM, 99204WM, 99211WM, 99212WM. 99213WM, 99214WM, 99215WM, 99221WM, 99231WM, 99232WM, 99351WM, 99352WM, 99384WM, 99385WM, 99386WM, 99387WM, 99394WM, 99395WM, 99396WM, 99397WM.)

1. Initial visit codes are as follows:

i. 99201WM, 99202WM

QUALIFIER: An Initial Office Visit is limited to a single visit. Future use of this category of codes will be denied when the beneficiary is seen by the same practitioner, group of practitioners, or member of the same shared health care facility.

ii. QUALIFIER: HCPCS procedure codes 99201WM and 99202WM are exceptions to the requirements outlined in the qualifier for the initial visit. For codes 99201WM and 99202WM, the provider is expected to follow the qualifier applied to routine visit or follow-up care visit for reimbursement purposes.

iii. QUALIFIER: Evaluation and Management services pertain to patients presenting with symptoms, and as such, exclude Preventive Health Care. Preventive services for patients through 20 years of age are billed under EPSDT, when the procedure requirements are met, as described at N.J.A.C. 10:58-2.3.

2. New patient codes are as follows:

i. 99203WM, 99204WM--Office or other Outpatient services: New Patient.

3. Hospital inpatient services codes are as follows:

i. 99221WM Hospital inpatient services: Initial hospital care; QUALIFIER: When

reference is made in the CPT manual to the procedures listed above, the intent of Medicaid/NJ FamilyCare-Plan A fee-for-service is to consider this service as the Initial Visit.

ii. QUALIFIER: Reimbursement for an initial office visit will be disallowed, if a preventive medicine service or EPSDT examination were billed within a twelve monthperiod by a practitioner, group, shared health care facility, or practitioners sharing a common record.

iii. QUALIFIER: In reference to a hospital, the Initial Visit concept will still apply for reimbursement purposes. Subsequent readmissions to the same facility may be reimbursed as Initial Visits, if the readmission occurs more than 30 days from a previous discharge from the same facility by the same provider. When the readmission occurs within 30 days from a previous discharge, the provider shall bill the relevant HCPCS procedure codes specified under the headings Subsequent Hospital Care.

iv. QUALIFIER: Initial hospital visit during a single admission will be disallowed to the same practitioner, group, shared health care facility, or practitioners sharing a common record who submit a claim for a consultation and transfer the patient to their service.

4. Follow-up Visit: Office or other Outpatient services: Established patient codes are: 99212WM, 99213WM, 99214WM.

5. Hospital Inpatient services: Subsequent Hospital care codes are: 99231WM, 99232WM.

6. Home Visit codes are: 99351WM, 99352WM, 99341WM, 99342WM, 99351WM, 99352WM.

i. QUALIFIER: When reference is made in the CPT manual to the services specified above, the intent of Medicaid/NJ FamilyCare-Plan A fee-for-service is to consider this service as the Routine Visit or Follow-Up Care visit. For purposes of Medicaid reimbursement, these codes apply when the provider visits Medicaid /NJ FamilyCare-Plan A fee-for-service beneficiaries in the home setting and the visit does not meet the criteria for a house call.

7. Preventive Medicine Services: Annual Health Maintenance Examination codes are:

New Patient	Established Patient
99384 WM	99394 WM
99385 WM	99395 WM
99386 WM	99396 WM

99387 WM 99397 WM

i. QUALIFIER: Preventive medicine services codes (new patient) 99384WM, 99385WM, 99386WM, and 99387WM may only be billed once within 12 months when the beneficiary is seen by the same practitioner, group of practitioners sharing a common record, or member(s) of a shared health care facility. These codes will also be automatically denied for payment when used following an EPSDT examination (procedure code W9820) performed within the preceding 12 months.

ii. Preventive medicine services codes (established patient) 99394WM, 99395WM, 99396WM and 99397WM may be used only once in a 12-month period for any individual over two years of age.

8. Emergency Room Services: CNM's Use of Emergency Room Instead of Office codes are: 99211WM, 99212WM, 99213WM, 99214WM, 99215WM.

i. When a CNM sees her patient in the emergency room instead of his or her office, the CNM shall use the same codes for the visit that would have been used if seen in the CNM's office (99211WM, 99212WM, 99213WM, 99214WM or 99215WM only). Records of that visit should become part of the notes in the office chart.

W9820 WM Early and Periodic Screening, Diagnosis and Treatment (EPSDT) through age 20.
QUALIFIER: Procedure code W9820 shall be used only once for the same patient during any 12-month period by the same practitioner(s) sharing a common record.
QUALIFIER: Reimbursement for code W9820 is contingent upon the submission of a completed "Report and Claim for EPSDT/HealthStart Screening and Related Procedures" (MC-19) form within 30 days of the date of service.

(f) Obstetrical services:

59400 WM Total obstetrical care including antepartum care consisting of initial antepartum visit and seven subsequent antepartum visits, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care when performed by a certified nurse midwife. If fewer than eight antepartum visits and one postpartum visit are provided, this HCPCS code must not be used for billingpurposes. In this situation, each visit must be billed individually with the appropriate procedure code designation. Include delivery date on the HCFA 1500 claim form in Item 24A.

ADDITIONAL VISITS ABOVE SEVEN ANTEPARTUM VISITS--99211WM, 99212WM, 99213WM, 99215WM, 99351WM, 99352WM

NOTE: If medical necessity dictates, corroborated by the record, then additional visits (home or office) above seven antepartum visits may be reimbursed. The claim form should clearly indicate the medical necessity and the date for each office or home visit listed.

59409 WM VAGINAL DELIVERY ONLY, WITH OR WITHOUT EPISIOTOMY AND/OR FORCEPS BY A
CERTIFIED NURSE MIDWIFE

59410 WM REGULAR DELIVERY AND POSTPARTUM VISIT BY A CERTIFIED NURSE MIDWIFE
This applies to a vaginal delivery (full term or premature, with or without episiotomy, and/or forceps) and includes one out-of-hospital visit between the 15th and 60th postpartum day following delivery. Include delivery date on the claim form in Item 24A on the HCFA 1500 claim form.

59430 WM Postpartum visit by other than the delivering physician or delivering certified nurse midwife. One out-of-hospital visit between the 15th and 60th postpartum day.

W9855 WM Initial Antepartum visit by a Certified Nurse Midwife. (Separate procedure.)

W9856 WM Subsequent Antepartum Visit by a Certified Nurse Midwife. (Separate procedure.) Indicate the specific dates of service on the HCFA 1500 claim form on Item 24.

(g) HealthStart Maternity Medical Care Services codes are as follows:

W9025 WM HealthStart INITIAL ANTEPARTUM MATERNITY MEDICAL CARE VISIT BY
CERTIFIED NURSE MIDWIFE
HealthStart INITIAL ANTEPARTUM MATERNITY MEDICAL CARE VISIT BY CERTIFIED NURSE MIDWIFE includes:

1. History, including system review
2. Complete physical examination
3. Risk assessment
4. Initial care plan
5. Patient counseling and treatment
6. Routine and special laboratory tests on site, or by referral, as appropriate

7. Referral for other medical consultations, as appropriate (including dental)
8. Coordination with the HealthStart Health Support Services provider, as applicable.

W9026 WM HealthStart SUBSEQUENT ANTEPARTUM MATERNITY MEDICAL CARE VISIT BY CERTIFIED NURSE MIDWIFE

HealthStart SUBSEQUENT ANTEPARTUM MATERNITY MEDICAL CARE VISIT BY CERTIFIED NURSE MIDWIFE includes:

1. Interim history
2. Physical examination
3. Risk assessment
4. Review of plan of care
5. Patient counseling and treatment
6. Laboratory services on site or by referral, as appropriate
7. Referrals for other medical consultations, as appropriate
8. Coordination with HealthStart case coordinator.

NOTE: This code may be billed only for the second through 15th antepartum visit.

NOTE: If medical necessity dictates, corroborated by the record, additional visits above the 15th visit may be reimbursed under procedure code for routine or follow-up visit--midwife, that is, OFFICE: 99211WM, 99212WM, 99213WM, 99214WM, 99215WM, or HOME: 99351WM, 99352WM. The date and place of service shall be included on each claim detail line on the HCFA 1500 claim form. The claim form should clearly indicate the reason for the medical necessity and date for each additional visit.

W9027 HealthStart REGULAR DELIVERY BY CERTIFIED NURSE MIDWIFE

HealthStart REGULAR DELIVERY BY CERTIFIED NURSE MIDWIFE includes:

1. Admission history
2. Complete physical examination
3. Vaginal delivery with or without episiotomy and/or forceps
4. Inpatient postpartum care
5. Referral to postpartum follow-up care provider including:
   i. Mother's hospital discharge summary and
   ii. Infant's discharge summary, as appropriate

NOTE: Obstetrical delivery applies to a full term or premature vaginal delivery and includes care in the home, birthing center or in the hospital (inpatient setting). Include the delivery date on the HCFA 1500 claim form in Item

24A.

W9028 WM HealthStart POSTPARTUM CARE VISIT BY CERTIFIED NURSE MIDWIFE

HealthStart POSTPARTUM CARE VISIT BY CERTIFIED NURSE MIDWIFE includes:

1. Outpatient postpartum care by the 60th day after the vaginal or caesarean section delivery
   i. Review of prenatal, labor and delivery course;
   ii. Interim history, including information on feeding and care of the newborn;
   iii. Physical examination;
   iv. Referral for laboratory services, as appropriate;
   v. Referral for ongoing medical care when appropriate;
   vi. Patient counseling and treatment;

NOTE: The postpartum visit shall be made by the 60th postpartum day. Include the delivery date on the HCFA 1500 claim form in Item 24A.

W9029 WM HealthStart REGULAR DELIVERY AND POSTPARTUM BY CERTIFIED NURSE MIDWIFE

HealthStart REGULAR DELIVERY AND POSTPARTUM BY CERTIFIED NURSE MIDWIFE includes:

1. Admission history
2. Complete physical examination
3. Vaginal delivery with or without episiotomy and/or forceps
4. Inpatient postpartum care
5. Referral to postpartum follow-up care provider including:
   i. Mother's hospital discharge summary;
   ii. Infant's discharge summary, as appropriate.
6. Outpatient postpartum care by the 60th day after the delivery
   i. Review of prenatal, labor and delivery course;
   ii. Interim history, including information on feeding and care of the newborn;
   iii. Physical examination;
   iv. Referral for laboratory services, as appropriate;
   v. Referral for ongoing medical care when appropriate;
   vi. Patient counseling and treatment.

NOTE: This code applies to a full term or premature vaginal delivery and includes care in the home, birthing center or in the hospital (inpatient setting). Include delivery date on the HCFA 1500 claim form in Item 24A.

W9030 WM HealthStart TOTAL OBSTETRICAL CARE BY CERTIFIED NURSE

MIDWIFE

Total obstetrical care consists of:

1. INITIAL ANTEPARTUM VISIT AND FOURTEEN SUBSEQUENT ANTEPARTUM VISITS BY THE CERTIFIED NURSE MIDWIFE. Specific dates are to be listed on the claim form.

NOTE: Reimbursement will be denied if the services delivered do not meet the criteria for the visits. The elements of the visits shall include the following:

i. History (initial or review), including system review;
ii. Complete physical examination;
iii. Risk assessment;
iv. Initial and ongoing care plan;
v. Patient counseling and treatment;
vi. Routine and special laboratory tests on site, or by referral, as appropriate;
vii. Referral for other medical consultations, as appropriate (including dental);
viii. Coordination with the HealthStart Health Support Services provider, as applicable.

2. REGULAR VAGINAL DELIVERY BY CERTIFIED NURSE MIDWIFE: The elements of the care shall include the following:

i. Admission history;
ii. Complete physical examination;
iii. Vaginal delivery with or without episiotomy and/or forceps;
iv. Inpatient postpartum care.

NOTE: Include the delivery date on the HCFA 1500 claim form in Item 24.

3. POSTPARTUM CARE VISIT BY CERTIFIED NURSE MIDWIFE: Outpatient postpartum care by the 60th day after the vaginal delivery (full term of premature):

i. Review of prenatal, labor and delivery course;
ii. Interim history, including information on feeding and care of the newborn;
iii. Physical examination;
iv. Referral for laboratory services, as appropriate;
v. Referral for ongoing medical care when appropriate;
vi. Patient counseling and treatment.

DRUG EFFICACY STUDY IMPLEMENTATION (DESI)

(Update of drug products and known related drug products that lack substantial evidence of effectiveness)

Appendix A in N.J.A.C. 10:51, incorporated herein by reference, is a list of drugs that the Food and Drug Administration (FDA) has proposed to withdraw from the market which is updated periodically by the Health Care Financing Administration subsequent to published listing changes in the Federal Register.

AGENCY NOTE: The Appendix A is filed as part of this chapter by reference but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Appendix A, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Appendix A, write to:

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Trenton, NJ 08650-4801

or contact:

Office of Administrative Law

Quakerbridge Plaza, Building 9

PO Box 049

Trenton, NJ 08625-0049

FISCAL AGENT BILLING SUPPLEMENT

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EMC MANUAL

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